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8 December 2007

Industry stands firm over EHC criticism

Life under the Tories – how would you fare?

- CPD: dealing with vitamin B_{12} deficiency
- Enhanced services: getting support from your staff

THE POWER TO

CHAMPIX® Film-Coated Tablets (varenicline tartrate) **ABBREVIATED PRESCRIBING INFORMATION – UK (See Champix Summary of Product characteristics for full Prescribing Information).** Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg **Presentation:** White, capsular-shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX 0.5" on the other side and light blue, capsular shaped, biconvex tablets debossed with *"Pfizer"* on one side and "CHX [illegible]" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** [illegible] mg varenicline twice daily following a 1-week titration as follows: [illegible] daily Days 4-7 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. Patients should set a date to stop smoking. Dosing should start 1-2 weeks before [illegible]. If intolerable adverse effects may have the dose lowered temporarily [illegible] mg twice daily. Patients should be treated with Champix for 12 weeks. For [illegible] who stopped smoking at the end of 12 weeks, an additional course [illegible] mg twice daily may be considered. Following the end of treatment, [illegible] patients with a high risk of relapse. **Patients with renal** [illegible] and moderate renal impairment: No dosage adjustment is necessary. *Patients* [illegible] *adverse events:* Dosing may be [illegible] daily is recommended. Dosing [illegible] to 1 mg once daily. *Patients with end stage renal disease:* Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** *Effect of smoking cessation;* Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product

[illegible] Pharmacia 2007 CHAMPIX

HELP THEM QUIT.[1-3]

- **First-in-class oral prescription therapy with a unique dual action:**[1,2,4]
  - – **Partial agonist** action: Reduces craving and withdrawal symptoms†
  - – **Antagonist** action: Reduces the satisfaction associated with smoking†
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**[1,2,5]
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**[6]

† Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Quastionnaira of Smoking Urges (QSU-brief) and modified Cigarette Evaluation Questionnaire (mCEQ).

ffects their ability to perform these activities. **Side-Effects**: Adverse reactions during clinical ials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, somnia, headache and nausea. Commonly reported side-effects were increased appetite, mnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach scomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported de-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has een shown to be dialyzed in patients with end stage renal disease, however, there is no experience dialysis following overdose. **Legal category:** POM **Basic NHS cost**: Pack of 25 11 x 0.5 mg nd 14 x 1mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1mg tablets Card (EU/1/06/360/004) 27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1mg tablets DPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1mg tablets Card (EU/1/06/360/005) £54.60. ot all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** fizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer mited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

dverse events should be reported to Pfizer Medical Information on 01304 616161. Information bout adverse event reporting can also be found at www.yellowcard.gov.uk

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. **2.** Jorenby DE *et al.* JAMA 2006; 296:56-63. **3.** Tonstad S *et al.* JAMA 2006; 296:64-71. **4.** Coe JW *et al.* J Med Chem 2005; 48:3474-3477. **5.** Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. **6.** CHAMPIX Summary of Product Characteristics.

CHAMPIX
varenicline tartrate

The new look Care Cough & Cold Range. It's all the rage in pharmacies this season.

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[1] MAT data 2007

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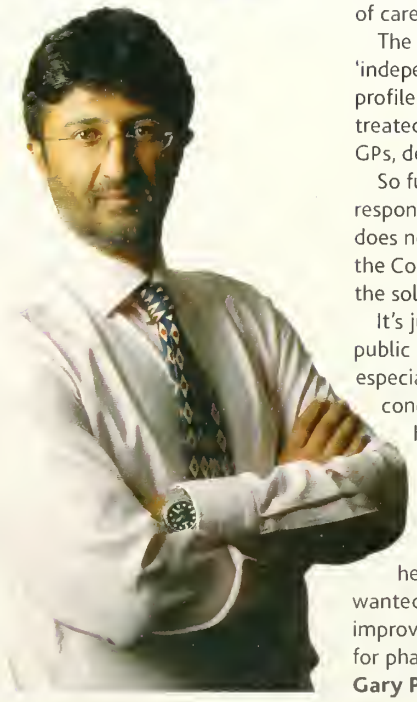
Chemist + Druggist
news education tools for the pharmacy community

Comment from the Editor

> Pharmacists have a duty of care to their patients, whatever their age



"Thousands of chemists hand out emergency contraceptive on demand to under-age girls," the Daily Mail's front page reported on Monday. Under a "controversial" government scheme to cut teenage pregnancies, young women seeking EHC are "asked only basic questions in a brief consultation with a pharmacist", the paper claimed (p6). While it's not the first time we've seen such headlines, and it certainly won't be the last, it still makes the blood boil.

GPs are not criticised for providing the same service to their patients, so why is community pharmacy the subject of the Daily Mail's scorn? As with all health professionals, pharmacists have a duty of care to their patients, no matter what their age.

The outdated view of community pharmacists operating 'independently' of the NHS does little to boost the sector's public profile. Pharmacists are an integral part of the NHS and should be treated no differently from other independent health providers such as GPs, dentists and opticians.

So full marks to RPSGB president Hemant Patel for his quick response to the Daily Mail explaining that pharmacy supply of EHC does not encourage unsafe sex or increase use of EHC, and adding that the Committee on the Safety of Medicines believes that EHC is part of the solution to cut down on teenage pregnancies.

It's just a pity the Department of Health – with its pharmacy and public health hats on – didn't come out publicly and support pharmacy, especially given it has in the past stated that reducing the under-18 conception rate through the use of EHC under PGDs was a public health priority for pharmacy.

This statement was one of eight priorities set out in Choosing Health through Pharmacy, the DH's 10-year programme for developing pharmaceutical public health services. In the foreword to the document, issued in 2005, the then pharmacy and public health ministers Rosie Winterton and Melanie Johnson said they wanted to "expand the contribution" of pharmacists and their staff in improving health and that the strategy would "open up opportunities" for pharmacy. Now that would be a good Christmas present.

Gary Paragpuri, Editor

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EHC concerns spark anger

Pharmacists defends the supply of EHC under patient group direction

Zoe Smeaton

Industry leaders have reacted angrily to reports highlighting concerns over pharmacists' provision of emergency hormonal contraception to young girls.

A report from the Family Education Trust said making the drug available could be increasing promiscuity among young girls, and it urged pharmacies to reconsider their policies.

A subsequent report in the Daily Mail claimed that youngsters are able to access EHC with "growing ease". It stated: "Under a controversial government scheme to cut teenage pregnancies, youngsters are asked only basic questions in a brief consultation with a pharmacist."

But industry leaders defended the ability of pharmacists to make professional judgements on when to provide the treatment.

Online games such as Sperm-catcher, above, are just one of the ways that the charity, Brook, provides sexual health information to over 200,000 young people each year

Hemant Patel, RPSGB president, sent a letter by email to the editor of the Daily Mail following the report. He pointed to evidence from Imperial College London that showed making EHC available through pharmacies had not encouraged unsafe sex or increased usage of the drug.

The profession also received backing from the House of Lords. Lady Finlay, cross bench peer and president of the Royal Society of Medicine, said young girls asking for EHC were often making a cry for help.

She added that pharmacists should respond to that by offering them the drug where appropriate as well additional advice on issues such as STDs.

Lady Finlay said: "If anyone thinks when a kid has had sex that you achieve anything at all from not giving them the morning-after pill, I think they need to wake up."

Colette McCreedy, director of pharmacy practice at the NPA, added: "Pharmacy supply of EHC commissioned by PCTs takes place within local protocols, within a professional ethical framework and by appropriately trained staff, ensuring that what is provided is a package of care, not just a packet of pills."

Is your EHC service a success?
haveyoursay@cmpmedica.com

Viagra provision can boost men's health

Dispensing Viagra under schemes such as patient group directives could reduce male patients' exposure to online counterfeits and increase diagnosis of other conditions, experts have said.

On November 29 the British Medical Association raised concerns about the dangers of patients self-diagnosing and receiving counterfeits when buying prescription drugs such as Viagra online.

It also emphasised the need for a proper consultation to assess related conditions such as hypertension, diabetes or depression.

Dr Ian Banks, president of the Men's Health Forum, said if pharmacists were prepared to ask questions about men's symptoms, and to do blood pressure, cholesterol and diabetes tests, then letting them provide the drug could be "a huge bonus" for men.

He said: "Men are more likely to go to their pharmacist than their GP, and this fits very well with pharmacy's new contract."

In February Boots ran a pilot scheme under a PGD, providing the drug to men who had undergone a thorough consultation and health check.

Colette McCreedy, director of pharmacy practice at the NPA, said the association would, in principle, support initiatives to boost men's health through community pharmacy.

A spokesperson from Pfizer, manufacturer of Viagra, said the company would support initiatives that could help patients obtain advice from a qualified healthcare provider and potentially enable early diagnosis of underlying health conditions. JR

NPA backs College plans

The National Pharmacy Association has backed the Royal Pharmaceutical Society's plan to form a professional leadership body.

Speaking at an evidence submission of the Clarke Inquiry on Wednesday, head of practice Colette McCreedy said the NPA favoured a Royal College-style body to represent pharmacists and pharmaceutical scientists.

She said: "When health issues arise on medicine, doctors should not be the first port of call for journalists and politicians, we should.

"A Royal College should draw on the expertise of all its members to make our voice heard."

Ms McCreedy added that a voluntary Royal College would not be "shackled by a regulatory function" but that it would have to "fight for members". **JC**

Do you want a Royal College for pharmacy?
haveyoursay@cmpmedica.com

Scotland outlines script plans

The Scottish Government has announced detailed proposals for abolishing prescription charges.

Health and wellbeing secretary Nicola Sturgeon confirmed to the Scottish Parliament on Wednesday that prescriptions would be free by April 2011, one year ahead of the ruling Scottish National Party's manifesto commitment.

The abolition will be phased, beginning with a reduction from the current £6.85 charge to £5 on April 1 next year.

Those with chronic conditions and those in full-time education or training will not immediately enjoy free prescriptions, as the Party's manifesto promised. Instead, the cost of prescription pre-payment certificates (PPCs), which cover all prescriptions for a four or 12 month period for those who regularly need medicines, will be cut by over 50 per cent from April 1.

"This substantial reduction in the cost of PPCs is the simplest and most effective way of providing direct financial support to people with chronic conditions," Ms Sturgeon said. **JC**

Membership funds £1m shortfall in premises fee

RPSGB warns deficit per pharmacy will be financed through individual fees

Jennifer Richardson

Pharmacists are shouldering a deficit of £1 million after the Department of Health rejected the Royal Pharmaceutical Society's request for a 56 per cent increase in premises retention fees.

The RPSGB said failure to achieve its proposed increase meant it would suffer a shortfall of £81 per pharmacy that would be financed through membership funds. This equates to £1m, based on the 12,895 pharmacy premises registered with the Society.

The Society emphasised, however, that this would not directly lead to a further increase in individual retention fees.

"The shortfall will have to be met through membership fees, which effectively results in a burden of £22 per member," said a Society statement. But a spokesperson confirmed: "There are no plans to increase fees in the future to cover the premises fees shortfall."

The decision by the DH to set the fee at £162, an increase of just 3.8 per cent on last year's £156 charge, follows fierce opposition from contractor representatives PSNC, NPA, CCA and AIMp to the Society's initial proposal of £243.

As the premises fee had been increased by similarly conservative amounts in previous years, a 'contingency' pre-empting the DH decision had been factored in to the recent move to increase individual retention fees by 40 per cent, RPSGB treasurer Andrew Gush revealed.

"If the full increase applied for had been granted, then the Society's reserves would have risen and the need to increase members fees in the future would have been reduced," he said.

The NPA rejected the Society's claim that individual members needed to make up a premises fees deficit. Welcoming the DH's decision, NPA director of pharmacy practice Colette McCreedy said: "We do not believe that this should result in an increased financial burden on individual pharmacists."

However, Mr Gush said: "In the absence of any increases of premises fees in the future, any increases in the cost of regulation will inevitably have to fall on members rather than contractors."

'Let pharmacists prescribe all controlled drugs,' MPs told

Pharmacists should be allowed to prescribe all controlled drugs, the government's drugs advisor has told ministers.

Under the Advisory Council on the Misuse of Drugs' (ACMD) proposals, pharmacists would be able to supply or administer morphine and diamorphine using patient group directions, and apply to the Home Office for a licence to prescribe cocaine, diamorphine and dipipanone for the management of addiction, as doctors currently can.

The recommendations follow a consultation on nurse and pharmacist prescribing launched earlier this year. They were detailed in a letter from ACMD chairman Professor Sir Michael Rawlins to Home Office minister Vernon Coaker, and are subject to competence and robust clinical governance.

National pharmacy bodies welcomed the ACMD's proposals. NPA director of pharmacy practice Colette McCreedy said: "Allowing pharmacist and nurse independent prescribers to prescribe CDs will improve patient care and allow professionals to prescribe fully within their areas of competence."

Ministers are considering giving pharmacists rights to prescribe CDs

Ministers were considering the recommendation to extend prescribing to all controlled drugs, a Home Office spokesperson said.

Addiction charity Addaction said the ACMD's recommendations were "clinically sound". "There are enough checks and balances in place that we are convinced this is a good idea," a spokesperson said.

However, the likelihood of pharmacists prescribing cocaine to addicts seemed slim, as the Home Office had "no intention" of allowing them to do so. "This is because current guidelines on clinical management for drug dependency do not recommend prescribing cocaine or dipipanone," the spokesperson said.

Just three doctors have so far been granted a licence to prescribe cocaine for the management of addiction. "That makes it even more remote that pharmacists would ever get the ability to prescribe cocaine and diamorphine to addicts," said David Pruce, RPSGB director of practice and quality improvement.

PSNC head of NHS services Alastair Buxton pointed out the role would apply to a limited number of specialised pharmacists. **JR**

News in brief

High Court referral

A pharmacist reprimanded by the RPSGB Statutory Committee for taking home £2,000 found in a box of patient returns, has had her case referred to the High Court because the Council for Healthcare Regulatory Excellence thought the sanction too lenient.

Palliative care funding

The Scottish Government has announced it is to organise a workshop to consider how palliative care and out-of-hours services can be integrated into the community pharmacy contract. It has confirmed an uplift in funding for palliative care model schemes for 2007-08.

Scotland payments

The Scottish Government has relaxed deadlines determining eligibility for contract preparation payments, for pharmacists succeeding a contractor previously on an NHS board pharmaceutical list. Successor contractors must be on the pharmaceutical list by January 31 and submit contract preparation payment claims by March 31.

Update MCQs

Question seven for November's Pharmacy Update module 1421 (lung cancer) has been disallowed. C+D apologises for the error, and will not count this question towards the Update Knockout contest.

Reimbursement

The category M reimbursement price for phenytoin 100mg tablets (28 pack) will drop to £40 from January 1, the Department of Health has said. The confirmation follows an increase from £53.51 to £113.62.

New ABPI President

Chris Brinsmead, UK president of AstraZeneca, has been named president designate of the Association of the British Pharmaceutical Industry. He succeeds Nigel Brooksby of sanofi-aventis.

Bayer Schering award

The College of Pharmacy Practice is seeking entrants for the Bayer Schering Pharma Award and the Balmford Silver Jubilee Cup. Details from ian@collpharm.org.uk

Dispensary TALK

Will your business suffer over delays to EPS 2 rollout?

"It's going to have a positive effect because stage one is still having problems. I had it installed six months ago and it worked very well initially. Since then I've had problems. The barcode scans but the prescription doesn't come down."
Dhimant Patel, Healthways Chemists, Pinner

"I'm disappointed because stage one worked so well. I was hoping it would be done in line with the Department of Health schedule. I can't see any reason for delays. It almost seems it's been sabotaged politically."
Prakash Mahtani, Warwick Pharmacy, Victoria, London

WEB VERDICT:

Yes: 12%
No: 88%

Armchair view: Just 12 per cent of you think the news that the second phase of EPS will be delayed will have a negative impact on your business.

This week The Pharmacy Council on the Register of Drugs hit the headlines by stating [illegible] Write to the Home Office [illegible] www.chemistanddruggist.co.uk

Cancer reform strategy

Five-year plan praises role of community pharmacists

Zoe Smeaton

Pharmacists are set to play a key role in the delivery of a £370 million government strategy to boost cancer care.

The scheme, outlined this week in a report unveiled by health secretary Alan Johnson, will be delivered over five years and has been given the backing of pharmacy industry leaders.

It includes measures to improve patient care by focusing on areas such as prevention, faster treatment and fast-track drug approvals.

Strategies for prevention include considering whether to remove cigarette vending machines to help smokers quit, and an extension of screening programmes for breast and bowel cancer.

The report praised pharmacy for its previous work in the area and said the profession played an integral role in cancer care, particularly in prevention and diagnosis.

It stated: "The role that pharmacists have played in helping promote awareness of the signs and symptoms of lung cancer and in encouraging people with a persistent cough to visit their GP, provides an excellent example of the enhanced contribution that can be made."

Paul Gimson, lead pharmacist for long-term conditions at RPSGB, welcomed the report. He said: "People are starting to realise how pharmacists can complement other healthcare professionals. It's nice to get that recognition, and it reflects the work we have done on lung cancer and other cancers."

Colette McCreedy, director of pharmacy practice at the NPA, added that community pharmacists had already supported people living with cancer and took an active role in prevention through healthy living interventions.

She also welcomed the specific highlighting of community pharmacy's potential.

Mike Hancock CBE, MP for Portsmouth South, tests carbon monoxide levels in his lungs on a visit to Rowlands' Fratton Road pharmacy in Portsmouth last week. Pharmacist Oliver Carter and staff at the store supported November's Lung Cancer Awareness Month through an information campaign comprising posters and patient leaflets. Mr Hancock said: "It's vital that people know the signs and symptoms of the disease, and pharmacies are a good place to pick up information"

Cash for consultations

A primary care trust has offered contractors up to £10,000 to install consultation rooms in a bid to push for more pharmacy services.

Ashton, Leigh & Wigan PCT will reimburse contractors 75 per cent of their costs, up to a maximum of £10,000, for installations completed by April 15. The grants apply to rooms fitted in financial years 2006-07 and 2007-08, as well as upgrades for existing rooms.

Umesh Patel and Linda Scott, representing the PCT, said consultation rooms in more pharmacies would support the rollout of further enhanced services. **JR**

New options for your C+D subscription

C+D has introduced a new range of subscription packages for its data and publications.

From 2008 pharmacists will be able to access C+D content in print, electronic or web format or a combination of all three.

The changes have been made following significant investment in C+D's data products, particularly the maintenance of the PIP code, which is embedded into many pharmacies' PMR and EPoS systems.

Director of C+D Data David Watkinson said: "Subscriptions paid to C+D help support the management and publication of information to the industry. Pharmacists can be assured that recent investments into our infrastructure have secured our ability to ensure the continued publication of high quality news, views and data, both electronically and via print, well into the future."

Rates start at £110 for web-only access to prices, product descriptions and PIP codes on the C+D Data website at www.cddata.co.uk, rising to £240 for a full electronic and print package. They will be offered to subscribers when their current subscription expires during 2008.

A telephone helpline has been set up to answer any queries on 01858 438809.

Full details of the changes to C+D's subscription packages can be found on p18

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- **22% more Phenylephrine** for blocked or runny noses (12.2mg Phenylephrine hydrochloride)
- **Plus Guaifenesin** for chesty coughs (200mg Guaifenesin)

Lemsip Max All In One Lemon Essential Information

Active ingredients: Paracetamol 1000mg, Phenylephrine hydrochloride 12.2mg and Guaifenesin 200mg per sachet. **Indications:** For relief of the symptoms of colds and influenza, including the relief of aches, pains, sore throat, headache, nasal congestion, lowering of temperature and chesty cough. **Dosage Instructions:** Oral administration after dissolution in water. Adults and children over 12: One sachet dissolved by stirring. Dose may be repeated every 4-6 hours. No more than 4 doses should be taken in 24hrs. Not to be given to children under 12 without medical advice. **Contraindications:** Hypersensitivity to any of the ingredients. Severe coronary heart disease. Hypertension. **Precautions:** To be used with caution by patients with severe hepatic or renal dysfunction, Raynaud's Phenomenon, diabetes. Do not take with any other paracetamol-containing products. The product contains paracetamol and the stated dose must not be exceeded. Keep out of the reach of children. If symptoms persist, the patient should consult a doctor. Patients who are pregnant or are being prescribed medicine must seek a doctor's advice before taking this product. Phenylephrine may adversely interact with other sympathomimetics, vasodilators and beta-blockers. Drugs which induce hepatic microsomal enzymes, such as alcohol, barbiturates MAOI drugs and tricyclic antidepressants, may increase the hepatotoxicity of paracetamol, particularly after overdosage. Not recommended for patients currently receiving or within two weeks of stopping therapy with MAOIs. The speed of absorption of paracetamol may be increased by metoclopramide or domperidone and absorption reduced by cholestyramine. Guaifenesin may increase the rate of absorption of paracetamol. Guaifenesin may interfere with the diagnostic measurements of urinary 5-hydroxyindoleactic acid or vanillylmandelic acid. The anticoagulant effect of warfarin and other coumarins may be enhanced by prolonged regular daily use of paracetamol with increased risk of bleeding: occasional doses have no significant effect. Contains aspartame. **Side-Effects:** Adverse effects of paracetamol are rare, but hypersensitivity including skin rash may occur. There have been a few reports of blood dyscrasias including thrombocytopenia and agranulocytosis, but these were not necessarily causally related to paracetamol. Phenylephrine hydrochloride: High blood pressure with headache and vomiting, probably only in overdosage. Rarely palpitations. Also, rare reports of allergic reactions. **Legal Classification:** GSL. **Licence Holder:** Reckitt Benckiser Healthcare (UK) Ltd, Dansom Lane, Hull, HU8 7DS. **Licence Number:** PL 00063/0168 **Price:** £4.99 for 10s. **Date of preparation:** May 2007.

Information about adverse event reporting can be found at **www.yellowcard.gov.uk**
Adverse events should also be reported to Medical Services, Reckitt Benckiser Healthcare (UK) Ltd. Telephone 0500 455456.

[1] Compared to the leading All In One [2] AC Nielsen unit sales 52 w/e 8th September 2007 [3] AC Nielsen Cold and Flu database, Value Sales 52 w/e 6th October 2007

News in brief

Herbal remedy warning

The MHRA has issued a warning over the following unlicensed traditional Chinese medicine herbal products: Xiao Qin Long Wan, Chuan Xiong Cha Tiao Wan, Bai Tou Weng Wan and Xie Gan Wan. They are thought to contain aristolochic acids, which can cause kidney failure and cancer, and should be withdrawn from sale immediately. http://tinyurl.com/2fvtqe

Cooked food cancer fear

A new study claims chemicals produced in certain foods when they are fried, grilled or roasted can increase the risk of endometrial or ovarian cancer. Researchers at the University of Maastricht found that women who consume 40mg of acrylamide acid every day, the equivalent of a portion of chips, doubled this risk.

Hepatitis C campaign

The Department of Health is running a national campaign to raise awareness of hepatitis C. The FaCe It campaign will feature in national newspapers and on regional radio stations across England until December 16.

GSL Nicorette Inhalator?

The MHRA is seeking views on the proposal to reclassify Nicorette Inhalators from P to GSL. Comments for the consultation should arrive at the MHRA no later than January 15. http://tinyurl.com/yw8v94

Stop smoking success

NHS smoking cessation services are reducing health inequalities, according to researchers from the University of Bath and the University of Edinburgh. They found that smokers from poorer areas are using the NHS to get advice on quitting more than those from affluent areas

Praise from president

Royal Pharmaceutical Society president Sandy Patel praised hundreds of members who took part in the Society's Pharmacy 2020 consultation. More than 50 meetings were held in place across [illegible] views [illegible] The consultation closed on December 28.

Co-op's 1,000-store aim

Organic growth and acquisitions on target to meet expansion plan

James Clegg

The Co-operative Group has put ambitious growth plans into action with the acquisition of more than 50 new branches.

The UK's third biggest pharmacy chain this week revealed details of a deal to acquire 51 pharmacies and one non-dispensing outlet from PCT Healthcare.

The addition of the stores, which are located across the north of England and traded under the name of either Peak Pharmacy or Tims & Parker, brings Co-operative Pharmacy's total number of outlets to 779.

John Nuttall, managing director of Co-operative Pharmacy, said: "Our expansion plan is to have 1,000 stores within a two-year period. We don't think that's an unreasonable aim."

Mr Nuttall added that these plans would be achieved through "organic growth and acquisition".

In 2004 the chain had just 300 branches. Since then it has more than doubled that number by acquiring a further 190 branches. This summer another 236 pharmacies were added following the merger with United Co-operatives. This latest deal is the Co-operative Group's first major acquisition since the merger.

The chain is also in the process of rebranding and refurbishing existing branches under one national brand, The Co-operative Pharmacy, and hopes to have 600 stores branded by the year end.

Peter Cattee, managing director of PCT Healthcare, said that despite selling around half of the company's branches it would be "business as usual" for the regional multiple.

He said: "The day of the divestment we also bought one branch and we shall continue to look at acquisitions, which we are very well placed to consider now."

Majhu eyes top spot

A restaurant entrepreneur who branched into community pharmacy four years ago has snapped up three pharmacies as part of plans to build the biggest independent chain in Scotland.

Sanjay Majhu, chief executive of Apple Pharmacy, expanded the company's turnover to £11 million through the acquisition of GW Allan in Edinburgh, Alexandra Parade Pharmacy in Glasgow, and Murray Pharmacy in East Kilbride.

C+D can also reveal that the group has been granted a contract for a new outlet in Gartcosh, Glasgow, taking its total number of premises to 14.

Mr Majhu said: "We're looking to acquire more businesses and expand the group in 2008, and become the largest independent pharmacy group in Scotland."

Mr Majhu made his name with Harlequin Leisure, his Indian restaurant business, and was last week named Businessman of the Year at newspaper Eastern Eye's Scottish Asian Business Awards. **JR**

Dispensing errors have been tackled by the National Patient Safety Agency in two booklets advising pharmacists how to reduce the risk of errors. The guides will be sent out to pharmacists and are backed by the RPSGB. The advice focuses on design, encouraging dispensaries to simplify their working processes to help anticipate and prevent human errors. Another key recommendation is designing waiting areas that allow for confidential discussions about patients' medicines, illustrated above

Cat M fears still fresh

UniChem customers have voiced fresh concerns about the final settlement on category M prices, saying the changes could wipe up to £45,000 from their bottom line.

Chris Martin, president of UniChem's customer forums, said: "Category M is very much a concern that is going forward. I think we are still at a stage where we are waiting to see what the final figure negotiated between the Department of Health and PSNC will be."

The concerns were aired at UniChem's November round of customer forums, where customers across the country meet to discuss pressing issues.

Mr Martin said that some of those present had argued that a pharmacy dispensing around 7,000 items a month could lose between £40 and £45,000 from its bottom line. He said: "That's quite a substantial amount of money and that's the kind of money that has previously allowed people to invest in a consultation room and providing services."

Mr Martin added that the changes to category M introduced in September would first be reflected in pharmacists' December accounts. **JC**

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Freederm Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** For the topical treatment of mild to moderate inflammatory acne vulgaris. **Directions:** For adults, children and the elderly: Apply to the affected area twice daily after the skin has been thoroughly washed with warm water and soap. Enough gel should be used to cover the affected area. For cutaneous use. **Contraindications:** Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** For external use only and to be kept away from the eyes and mucous membranes, including those of the nose and mouth. If excessive dryness, irritation or peeling occurs reduce the dosage to one application per day or every other day. Although there are no specific restrictions to using Freederm during pregnancy or breast feeding, the potential risks are unknown. As with all medicines, care should therefore be exercised, particularly during the first trimester of pregnancy. Side-effects: The most frequently encountered adverse effect reported is dryness of the skin. Other less frequent adverse effects include pruritus, erythema, burning sensation and irritation. **Legal category:** P **Packs:** 25g, RSP £8.95. (£7.62 exc. VAT) PL 0173/0187 **Revision Date**: January 2005

Imigran Recovery is the only OTC treatment that tackles the symptoms and the root cause of migraine itself.[1,2] Just one tablet can start to work on migraine headache in 30 minutes. Within 2 hours, it helps sufferers function normally again[3] and can provide complete relief of headache and all major migraine symptoms.[4]

What could be more positive for your migraine customers?

Sumatriptan

Imigran Recovery 50 mg Tablets (sumatriptan) **Product** ischaemic attack; hypertension; hepatic or renal impairment; history of seizures, lowered seizure threshold; hemiplegic, basilar or ophthalamoplegic migraine. **Precautions** First migraine after age 50, assess risk factors for cardiovascular disease, typical headache > 24 hours, atypical symptoms, taking combined oral contraceptive pill, pregnancy or breast feeding **Interactions** MAOIs, ergots, SSRI, SNRIs, tricyclic antidepressants, St John's wort. **Side effects** Common: pain, heat, cold, heaviness, pressure or tightness affecting any part including chest and throat; may be usually transient Dizziness, drowsiness, sensory disturbances including pareasthesia and hypoaesthesia; muscle cramp. Feelings of weakness, fatigue. Very rare: hypersensitivity reactions, seizures, tremor, dystonia, nystagmus, coma, visual disturbances; cardiovascular disturbances including bradycardia, tachycardia, palpitations, arrhythmias, ischaemias, coronary artery vasospasm, angina, myocardial infarction, hypotension, Raynaud's, ischaemic colitis. **Legal category**: P. **Product licence number** PL 00071/0455. **Product licence holder** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP**. 2 tablets £7.99. **Date of revision** July 2007. **Imigran** is a registered trade mark of the GlaxoSmithKline group of companies.

References: 1. Goadsby PJ, Lipton RB, Ferrari MD. N Engl J Med 2002; **346**(4): 257-270. 2. Humphrey PPA. Cephalalgia 2001; **21** Suppl 1: 2-5. 3. Landy S, Savani N, Shackelford S *et al.* Int J Clinical Practice 2004; **58**(10): 913-919. 4. Winner P, Mannix LK, Putnam DG *et al.* Mayo Clin Proc 2003; **78**(10): 1214-1222.

Statin intolerant patients OK to take Ezetimibe

Treatment suggested as alternative for primary hypercholesterolaemia patients

Gavin Atkin

Nice has issued guidance recommending ezetimibe (Ezetrol, Merck, Sharp and Dohme and Schering-Plough) as an alternative primary hypercholesterolaemia treatment for patients unable to tolerate statins.

The organisation has also approved exetimibe for use together with statins in patients whose cholesterol levels are not appropriately controlled on statins either on full dose, or because the maximum statin dose they can tolerate is limited by side effects.

Statin intolerance is defined in the guidance as the presence of clinically significant adverse effects from statin therapy that represent an unacceptable risk to the patient, or that may lead to compliance with therapy being compromised.

The combined treatment recommendation represents a strategy of using a statin to reduce liver cholesterol production together with a treatment (ezetimibe) that blocks cholesterol absorption in the gut.

The Nice Guidance Committee considered evidence showing that adding ezetimibe to statin therapy reduced LDL-cholesterol by 23.2 per cent more than statin therapy alone, with no apparent increase in adverse effects.
www.nice.org.uk/TA132

Linking to ETP could cut errors

Linking dispensing to electronic transfer of prescriptions (ETP) could prevent nearly half of dispensing errors, say pharmacists at the NHS Centre for Medication Safety and Medication Quality.

Data collected from 11 UK pharmacies involving nearly 3,000 dispensed items identified 95 errors. The content error rate was 1.7 per cent and the labelling error rate was 1.6 per cent. Writing in the International Journal of Pharmacy Practice, the authors say that the majority of errors were not clinically significant.

Errors involving documentation, monitored dosage systems, patient counselling or clinical matters were not included.

The study also considered the likely impact of authentication at the point of dispensing, by using barcodes or radio frequency identification tags either as a stand-alone system or linked to a PMR or ETP system. None of the three would have prevented the single severe error but, of the 30 mistakes judged to be of moderate severity, authentication would have averted 22 to 60 per cent.
IJPP 2007; 15 (4): 273-281.

Sinusitis treatments may be ineffective

Common treatments for acute sinusitis including an antibiotic and a topical steroid have been shown to be no more effective than placebo, according to a comparison published by JAMA.

In the study, 240 patients with acute non-recurrent sinusitis symptoms at 58 family practices were randomised to four combinations of common treatments, including antibiotic and placebo antibiotic, and nasal budesonide and placebo nasal steroid.

The results revealed that the proportion of patients whose symptoms lasted at least 10 days were broadly the same in the groups receiving each of the four different possible combinations of treatments and placebo.

Further analysis revealed that topical steroids showed some benefit in patients with relatively mild symptoms, however.

An accompanying editorial observed that in most patients it was not possible to distinguish between viral and bacterial sinusitis.
JAMA 2007; 298: 2487–96 and 2007; 298: 2543–4.

Dosulepin precautions

Pack sizes of the tricyclic antidepressant dosulepin have been reduced in size, and health professionals have been warned to restrict prescribing quantities to reduce the risk of overdose. Additionally, initiation in new patients should be restricted to specialist prescribers, says the MHRA's latest Drug Safety Update.
http://tinyurl.com/3bkh7r

Cost rules asthma guidance

Cost minimisation appears to be the main thrust of the latest Nice guidance on inhaled corticosteroids for children under 12 years with chronic asthma.

The guidance states:

- For children in whom an inhaled corticosteroid (ICS) is considered appropriate, the least costly appropriate product should be used.
- For children requiring an ICS and a long-acting beta-2 agonist (LABA), either a combination product or two separate products may be used, taking into consideration therapeutic need and likely compliance. If a combination device is chosen, the least costly should be prescribed.

www.nice.org.uk/TA131

Turn to page 24 for more clinical news

MHRA EPO warning

Recombinant human erythropoietins should not be given to patients who do not fulfil the criteria for treatment in the cancer indications, the MHRA has warned.

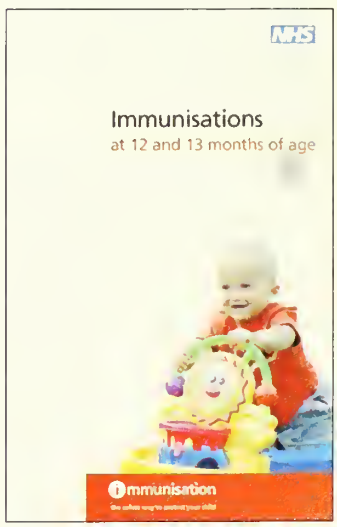
Over-correction of haemoglobin levels in patients with chronic kidney disease increases risk of death and serious cardiovascular events, and thrombosis in patients with cancer.

The agency has also published two public assessment reports presenting relevant evidence.
http://tinyurl.com/2n3gho

Try honey for kids' coughs

A dose of buckwheat honey before bed may give children better relief from cough and difficulty in sleeping than dextromethorphan or no treatment, according to a report in December's issue of Archives of Pediatrics & Adolescent Medicine.

A group of 105 children from two to 18 years were randomised to each treatment option. Using paired comparisons, the authors found honey was superior to no treatment for cough frequency, while dextromethorphan was no more effective than no treatment.
Arch Pediatr Adolesc Med 2007; 161: 1140–6.



Two leaflets on the childhood immunisation programme have been published by the Department of Health. The first booklet covers all the vaccines given up to 13 months of age but describes in detail those given at two, three and four months, whereas the second concentrates on the immunisation requirements at 12 and 13 months. See http://tinyurl.com/2kadeq for more information

THE BIG QUESTION

How would pharmacy fare under the Conservatives?

Shadow health secretary Andrew Lansley tells James Clegg how the Conservatives would tackle contracts, competition, commissioning and public health

How would pharmacy change under a Conservative government?

Andrew Lansley: To deliver a successful health service we have to be more effective at delivering support for people making positive lifestyle choices. Clearly there are pharmacists who we feel could deliver much more effectively on that.

There is a systematic failure to allocate resources to preventative health spending. We need a separate public health budget that is devoted in pursuance of agreed targets.

Pharmacists need to be in a position to make their case to local directors of public health to justify direct spending with them. So that's number one, a direct incentive to commission services from pharmacists.

How do you see that happening?

AL: If you create a director of public health who doesn't have the conflict of interest of having to support treatment costs and has a budget allocated for the purpose of delivering public health objectives, that director is going to look at the most cost-effective way of doing that.

The second thing is the relationship with GPs. I know there is concern on the part of pharmacists that as far as budgets and commissioning go, it's in the hands of GPs as primary care commissioners. If you're on a fee for service basis and you're a GP practice, you tend to do those things yourself. What we need to do is move to a reward structure for GPs that is outcome based. If they have budgets where the less they spend on one thing the more they can spend on something else, they have an inbuilt incentive to do that. So hopefully we can use GP commissioning in a way that creates a more positive relationship with pharmacists.

That brings me to the broader question of the contract. I get the impression from conversations with both independent pharmacists, small pharmacy chains and some of the larger chains that they are now very unhappy with how it is turning out.

Andrew Lansley (left) and David Cameron would bring in a more commercial contract

I think that is because the contract has been designed the wrong way around this complex process of cross-subsidisation. Pharmacies are commercial organisations; we should have a much more commercial contract, one where the government should pay for things in a way that is transparent and open to competition.

In terms of it being competitive, you mean pharmacists tendering for different services?

AL: In an area where there are a number of pharmacists they should be in a position where they must seek contracts with local commissioners. I don't see why the taxpayer should be other than in a situation of trying to get best value for money. Competition, in my experience, provides best value for money.

Would that not disadvantage smaller community pharmacies competing with larger chains?

AL: We have to make sure that the overall policy we design delivers our overall objectives. Our overall objectives include tackling health inequalities. So access to pharmacy services in deprived areas is obviously important. And we want to make sure we sustain access in rural areas and that is particularly important to small pharmacies in those areas.

Do you support a commitment to ensuring pharmacists have a place on practice-based commissioning groups?

AL: It's quite important, if you're designing a primary care trust that is engaged in contracting, to have pharmacy expertise as part of that process. It's very important in terms of understanding what the potential is for contracting services to pharmacy but also for securing best advice to primary care commissioners for prescribing activities.

How about ringfencing money for public health for community pharmacy?

AL: The money would not specifically be ringfenced for pharmacists. It's ringfenced for public health. Clearly pharmacists have to demonstrate their cost-effectiveness, and we have to assess the cost-effectiveness of different interventions and routes from which those interventions can be provided.

You've also been reported as saying that community pharmacists need greater financial stability and a return on their investment – how would you introduce that stability?

AL: Imagine you're a pharmacist at the moment and you've invested on the basis of the contract in consulting rooms and things of that kind because that's what the government has said you'll need. But the volume of people coming in isn't happening and the primary care trust isn't commissioning you. That's anything but stable.

It comes back to the fact that we need a contract designed around understanding the economic circumstances of pharmacies that pays in a much more predictable way for the services we're asking pharmacy to provide for us.

Do you agree with the Conservative vision?
haveyoursay@cmpmedica.com

Astellas Advertorial

Important announcement

New distribution arrangements for Astellas Transplant Medicines in the UK

It has been brought to our attention that UK pharmacists have had difficulties obtaining supplies of **Prograf®** for their patients from their wholesalers. The timely supply of all medicinal products is critical and it is particularly vital that transplant patients receive their prescribed medicines regularly.

In response, we have had to act with urgency to ensure the supply of these medicines to our transplant patients.

We have therefore taken the decision to distribute all our transplant medicines directly to pharmacists and other dispensing points with effect from 26th November 2007.

We have appointed **UniChem,** with its service and coverage expertise, as our sole distribution logistics service provider in the UK for all our transplant medicines. In Northern Ireland **UniChem** has sub-contracted **Sangers (NI) Ltd** to deliver these medicines on its behalf. We are confident this action will ensure the supply of these life saving medicines to UK patients.

To make this change as smooth as possible, there will be a handover period until 26th November 2007. Until this date, you will be able to order Astellas **Prograf®** and **Advagraf®** from your current wholesaler. The vast majority of dispensing points are already ordering some, or all, of their medicines through **UniChem/Sangers (NI) Ltd** and will be able to order our transplant medicines (**Prograf® and Advagraf®**) through their existing accounts. **UniChem/Sangers (NI) Ltd** will be contacting all customers shortly to confirm ordering processes. Any dispensing point that does not currently have a trading account with **UniChem/Sangers (NI) Ltd** and wishes to obtain our transplant medicines from 26th November 2007 should contact **UniChem** immediately on **0800 389 3455 or e-mail sales_customersupport@unichem.co.uk** or **Sangers (NI) Ltd** on 02890 401111.

To ensure the timely delivery of Astellas Prograf® and Advagraf® you should place orders directly with UniChem from 26th November 2007.

If you have any enquiries regarding this change or if you experience issues ordering **Prograf®/Advagraf®** please contact Astellas Customer Services on **01784 419 615.** For medical information about **Prograf®/Advagraf®** please contact our medical information department on **0800 783 5018.**

Please note this change only applies to our transplant medicines. All other Astellas Pharma Ltd products can be ordered in the normal way.

We hope you understand that this decision was not taken lightly. Our responsibility as holders of the UK marketing authorisation for **Prograf®** and **Advagraf®** is to ensure the supply of these vital medicines to pharmacists and their patients in the UK.

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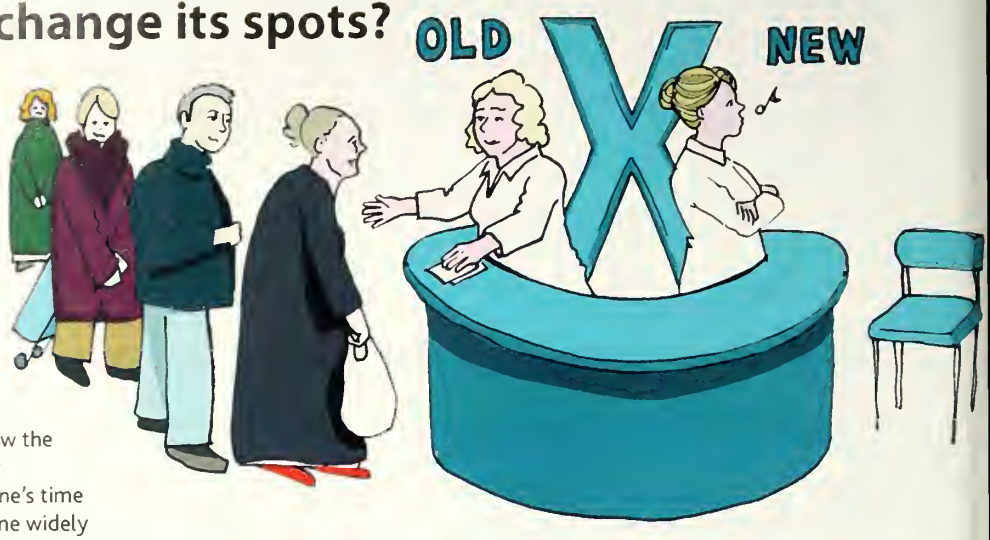
ASTPRG016-07 November 2007/C+D/WEB

Will the leopard ever change its spots?



Confucius said: "Only the wisest and stupidest of men don't change." You can't disagree with that, but the trick is knowing when you're being wise and when you're being stupid. It's much easier to see if changes being forced on you are one or the other, but often initiatives that look wise at first glance reveal themselves as less so with time. I used to think repeat dispensing was the future; likewise ETP. Now I wonder whether everything should stay the same. Forever.

Repeat dispensing made such perfect sense – patients on regular medication have prescriptions for six months' supply and I'm in control of when and how the medication is issued, as well as being able to monitor compliance. And patients don't have to waste everyone's time with five pointless visits to the surgery. Once it became widely adopted, all our systems would become geared around it and we would be one step closer to good pharmaceutical care.

But largely because the scheme wasn't widely adopted it has become nothing more than a nuisance. Too few patients are on the scheme, and those that are have their medication changed too often. They are often issued one-off prescriptions for new medication without any reference to their existing repeatable forms. Instead of monitoring compliance with regular medication I spend all my time chasing the surgery for new repeatable forms and dealing with the admin that goes with it.

Instead of following the wise old Chinaman's advice, local GPs prefer the words of the great yellow prophet from Springfield, Homer Simpson, who famously said: "If something's hard to do, then it's not worth doing." Because the repeat prescription scheme requires a little extra thought for no additional QOF points, the GPs don't bother. And it's a similar story for ETP and most other pharmacy initiatives.

News of further setbacks to ETP implementation (C+D, December 1, p8) is par for the course, and indicates that the system is unlikely to deliver as promised. And what promise it held – the whole prescription process handled quickly and efficiently without any paperwork. But with no financial incentives for GPs, and pharmacists excluded from the decision-making, it was never going to be a success. I predict that ETP will never properly replace the paper prescription and will become simply another waste of my time.

So why bother with any change at all? The old system worked pretty well, and most attempts at improvement backfire on us. We can process thousands of paper prescriptions easily and cost-effectively, and everybody knows where they stand. As my pharmacy's very own wise person, my dispenser Ann, once said: "I like dispensing paper prescriptions, all the patients like the way we do it, and we're really good at it. Why's it got to change?"

Is Xrayser right? Comment at www.chemistanddruggist.co.uk/xrayser

CCA comment

Rob Darracott

No time for complacency – we must keep our promises

I was going to apologise for returning to an old subject, but the news in last week's C+D (December 1, p9) about the jailing of a man for producing crystal meth in his Peterborough home means no apology is necessary.

When the Medicines and Healthcare products Regulatory Agency launched its consultation on reclassifying pseudoephedrine and ephedrine to POM in February, it took everyone by surprise. "Overkill," said some. "A sledgehammer to crack a nut," said others. "They should trust the profession," we all said.

Pharmacy's proposal to sell one pack at a time coupled with the industry's proposal to reduce [illegible] provided the solution that led the Commission on Human Medicines to recommend a delay in reclassification for two years. Now it's up to each and every one of us involved in the sale of OTC medicines to deliver on the reassurances given by the national pharmacy bodies that we can manage pseudoephedrine and ephedrine sales effectively.

The reclassification of pseudoephedrine is not yesterday's news. As C+D rightly pointed out last week, the MHRA can switch the nasal decongestants to POM at any time if a crystal meth production problem, using OTC medicines as precursors, emerges in the UK.

So, do you know what to do? The Society published updated guidance last week on handling pseudoephedrine sales, reiterating the general guidance of one pack per transaction. Has everyone involved in medicines sales in your pharmacy completed an awareness programme? There is no excuse for not doing so – they are available from a number of sources, including via C+D's website.

Selling one pack at a time is simple enough, but preventing the accumulation of sufficient packs to make an attempt at home production of crystal meth is vital too.

Awareness programmes provide the background to the issue, to help you explain the restriction to customers, but more importantly they reinforce to everyone why this must be taken seriously. They don't take very long to complete, whichever way you choose to do it.

So if you haven't got around to this yet, make time. If one Peterborough becomes a trend, you will be taking pseudoephedrine off the shelves for good.

Rob Darracott is chief executive, Company Chemists' Association

Do you agree with Rob? Email haveyoursay@cmpmedica.com

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(No applause please, it'll just go to its head.)

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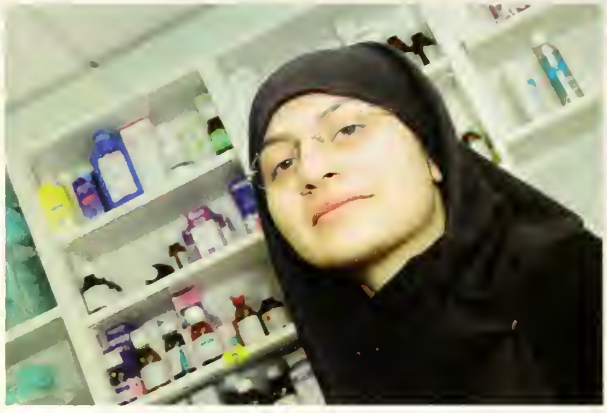
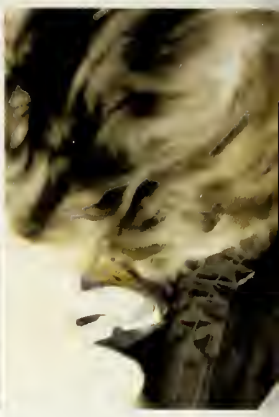




Some important changes to the

What's happening and why?

For many years pharmacists in the UK have found the information published each month in the C+D Price List invaluable, enabling them to order products, as well as to check prices and other product details.

However, the world has changed considerably since it was first published in the 1940s and greater usage is now made of the Price List in its electronic format rather than via the printed book. Although many pharmacists might not be aware of it, most dispensary computer systems and pharmacy EPoS systems incorporate elements of the C+D database. The computerised ordering that is the norm throughout the pharmacy sector relies heavily on the maintenance of accurate PIP codes to function effectively.

Today's pharmacists have varying needs and require a more flexible range of options that relates to the way they actually use the data and publications that C+D provides. From January 2008 we are introducing a new set of subscription options that reflect current habits and which will allow pharmacists to choose between print, electronic or web access or a combination of all of these. The options are explained in the accompanying table.

What about EPoS ?

In addition to the above, a number of pharmacists require additional product information (including PIP code, EAN code, till roll description, price, etc) to support their EPoS tills. To receive this electronic data your EPoS system supplier will ask you to sign an end-user licence at a cost of just £10 per month per shop.

Web access?

Pharmacists and others who only wish to access C+D Data via the web can find product descriptions, PIP codes, prices and much more at www.cddata.co.uk. The full dataset includes: downloadable pdfs of the weekly Price List Update; EAN barcodes; AMPP codes; pack dimensions; historical pricing; legal categories; and formulations. The cost of this is £10 per month or £110 annually.

Why has the price gone up?

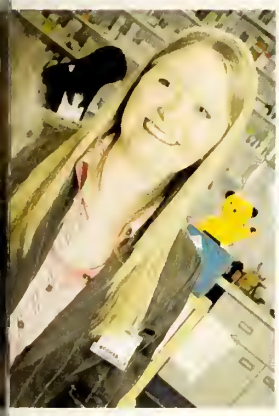
Pharmacists will already recognise that acquiring the services that help them run their businesses efficiently is unlikely to be free and comes with a cost, however there are a few reasons why C+D has found it necessary to restructure the subscription package.

C+D has made a large investment to upgrade the database to make it fit for the needs of today's, and more particularly tomorrow's, technology. In addition, the size of the database has grown considerably in recent years and now contains more than 80,000 products. The more data held, the more work there is in collating it and ensuring its accuracy. Finally, the costs of printing and posting the paper Price List have increased dramatically in recent years, outstripping any increase in the annual subscription.

What are the new options?

	Print £210	Electronic £180	Print and Electronic £240	Web only £110
C+D magazine	✓	✓	✓	
OTC magazine	✓	✓	✓	
Weekly price update	✓	✓	✓	
C+D Data website	✓	✓	✓	✓
C+D Monthly pricelist book	✓		✓	
Electronic data for PMR systems		✓	✓	

Prices quoted are for annual subscriptions in 2008



C+D subscription package

C+D recognises that no business welcomes a price increase so we have ensured that subscribers have at least one 'no-increase' option. This means pharmacies can still receive C+D and Over the Counter magazines and access to the data they need to continue ordering products at a slight saving compared to the 2007 price.

The government has recognised that pharmacy businesses incur IT costs in delivering pharmacy services and is making specific payments to contractors to ensure that pharmacies are equipped to meet the challenges presented by technology. Data is just one aspect of the technological challenges facing pharmacy but it is an important building block in the whole process.

What if I don't subscribe to the electronic (ordering) file?

You don't have to subscribe, but you should think carefully about the impact it might have on your business if you don't. C+D Data, which includes the PIP code and other valuable information, is incorporated into both dispensary and front-of-shop systems by the system suppliers, who do so under licence. If you do not have an appropriate subscription you will not have the right to access our data electronically in your systems and you may find activities such as ordering more difficult.

What are the timescales for these changes?

The new subscription scheme will be rolled out during 2008. Your current subscription will continue as normal until your 2008 expiry date, after which time you will be offered the new choice of subscription packages as you approach renewal.

What action do I (a pharmacist or pharmacy owner) need to take?

If you are a current subscriber, C+D will contact you in the normal way before your subscription expires. We will set out the options available to you and be on hand to give you any advice you require via our telephone helpline.

If you are not a current subscriber you will need to subscribe to a relevant package in order to continue to be able to use the PIP code and other C+D Data in your pharmacy computer system (for example, to order products via your computer system). You should contact the C+D subscription hotline urgently to arrange the relevant subscription.

If you require C+D data to support your EPoS tills, you will have to pay for an end-user licence to obtain this data. Your EPoS system supplier will arrange this.

What are the benefits to pharmacists of the changes?

- A single standardised data source, which is updated weekly based on information provided by manufacturers
- Accurate, up-to-date data on 80,000+ products (on average we process some 26,000 updates every year in order to provide the reliability your business needs)
- Access via the web to data not previously published for answering ad hoc queries
- EPoS file with expanded availability of EAN codes and EAN code history, plus an expanding range of products
- Pack dimensions (for those with robots or plannogramming software)
- The developments mean that more products will scan at point of sale, improving the speed at which you can deal with customers and patients
- Automatic linking of PIP, EAN and AMPP codes to facilitate ETP
- Two great magazines – C+D and OTC – delivered to your door

If you have any questions or wish to discuss your subscription, call our hotline on

01858 438809 Or visit **www.chemistanddruggist.co.uk/subs**

Embracing the MUR challenge

Are you looking forward to the opportunity the MUR initiative could offer your pharmacy? Teva can help you get started with a MUR Resource Pack* that's designed to help the independent pharmacist get up and running. It won't run MURs for you, of course, but we've focused on the practical, hands-on side of the equation to help make taking the plunge into MURs as simple as we can.

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*While stocks last – eligibility criteria available on request

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PARTNERS IN PROGRESS

C+D Clinical

New perspectives on vitamin B_{12}

Recent advances include improved diagnostic tests for cobalamin deficiency and possible oral treatment

Key points

- Vitamin B_{12} deficiency, whose prevalence increases with age, is a common cause of megaloblastic anaemia and can trigger a spectrum of neuropsychiatric disorders.
- Early diagnosis and prompt treatment improves the prognosis. Prolonged deficiency can result in serious and irreversible subacute combined degeneration of the spinal cord.
- Prescribed medications have been implicated in cobalamin deficiency.
- Pharmacists should be aware of the signs and symptoms so they can promptly refer suspect cases.
- Contrary to the traditional treatment with intramuscular cobalamin, recent studies show equal efficacy with high dose oral cobalamin.

Dinesh Jivanji MRPharmS

Vitamin B_{12}, also known as cobalamin, is an essential vitamin found only in foods of animal origin such as milk, poultry, red meat, eggs and fish. Cobalamin plays an important role in DNA synthesis and neurological function. The body stores sufficient cobalamin to prevent deficiency occurring for about four years following total cut-off by malabsorption. This is because the liver stores most of the body's cobalamin and over 75 per cent of cobalamin excreted in the bile is reabsorbed via the enterohepatic circulation.

Cobalamin deficiency is common, with epidemiological studies estimating around 20 per cent of the general population in industrialised countries to be affected. The incidence appears to rise dramatically with age, with studies of elderly patients in institutions or who are sick showing a prevalence of up to 40 per cent. Healthcare professionals need to be aware that the condition may be asymptomatic or present with an array of haematological and neuropsychiatric abnormalities. This means the condition may remain undiagnosed, resulting in serious and irreversible complications. Early treatment is crucial if haematological and/or neuropsychiatric

Reflect

What are the signs and symptoms of cobalamin (vitamin B_{12}) deficiency? What are the causes? Which drugs might interfere with cobalamin absorption?

Plan

You may have patients with undiagnosed cobalamin deficiency, which can result in serious complications. This article describes the clinical manifestations, causes, diagnosis and treatment of this condition.

CPD This article can help in the following CPD competencies: **G1a, G1c, C1a, C1d, C2e, C3b**. See www.tinyurl.com/194zu

Cobalamin deficiency is common, with around one fifth of the general population in industrialised countries affected

complications are to be avoided, and can often reverse symptoms. Pharmacists, in particular, can help ensure patients receiving lifelong cobalamin treatments do so regularly as recommended.

Manifestations (Table 1)

Cobalamin deficiency often goes unrecognised or is not investigated because of the subtle nature of the clinical manifestations. However, because of the potential seriousness of the complications, especially haematological and neuropsychiatric, it is crucial that all suspected cases are thoroughly investigated. Deficiency is a common cause of megaloblastic anaemia and, in severe cases, pancytopenia. As with folic acid deficiency, cobalamin deficiency is implicated in hyperhomocysteinaemia, an independent risk factor for cardiovascular disease.

Table 1: Some of the clinical manifestations of cobalamin deficiency

System	Manifestation
Haematologic	• Megaloblastic anaemia – causing symptoms like fatigue, breathlessness and pallor • Pancytopenia – eg thrombocytopenia (reduced blood platelet count)
Neuropsychiatric	• Subacute combined degeneration of the spinal cord – a symmetrical neuropathy affecting legs more than arms, causing parasthesiae and numbness (mainly feet), unsteadiness, ataxia and difficulty walking • Impotence, urinary or faecal incontinence • Visual disturbance – because of optic neuritis and optic atrophy • Irritability, personality change, mild memory impairment, depression, dementia, psychosis
Digestive	• Hunter's glossitis – causes lingual papillae to atrophy, rendering the tongue smooth and shiny • Dyspepsia and/or diarrhoea • Resistant and recurring mucocutaneous ulcers

Cobalamin absorption

To understand the aetiology of cobalamin deficiency, it is important to grasp the complex mechanisms involved in cobalamin absorption. A defect at any one of the step(s) involved can result in deficiency.

In the stomach, cobalamin is cleaved from animal proteins by gastric acid and pepsin. The free cobalamin binds to gastric R binder, a glycoprotein in saliva. In the small intestine, cobalamin is released from R binder by the action of pancreatic enzymes. The free cobalamin molecules are then linked to a substance called intrinsic factor (IF), which is synthesised in the gastric parietal cells. The cobalamin-IF complex enters the mucosal cells in the distal part of the small intestine and the IF is degraded by proteolysis. Free cobalamin is released into the systemic circulation where it binds to the protein transcobalamin II to form a complex called holotranscobalamin. After cellular uptake, cobalamin is freed from transcobalamin II and acts as a coenzyme for the synthesis of various enzymes required for DNA synthesis.

Causes of cobalamin deficiency can be broadly divided into three categories – nutritional deficiency, malabsorption syndromes and other gastrointestinal causes

Nutritional deficiency

This is a rare aetiology, but can occur in individuals who have been on strict vegan diets (no dairy products or eggs) for several years. A typical western diet provides approximately 5mcg of cobalamin daily which is more than the recommended daily allowance of 2mcg/day in adults.

Malabsorption syndromes

• **Pernicious anaemia (PA).** This condition accounts for 75 per cent of cases of cobalamin deficiency. PA is a consequence of autoimmune gastritis, which results in reduced/absent acid production and absent IF. The absence of IF prevents formation of the cobalamin-IF complex, which is necessary for the intestinal internalisation of cobalamin.

• **Food-cobalamin malabsorption.** This occurs when cobalamin bound to protein in foods cannot be released. Processes that interfere with gastric acid production can result in this type of malabsorption. The major culprit is atrophic gastritis, a condition associated with reduced hydrochloric acid secretion by the stomach. The prevalence of atrophic gastritis increases with age, which may explain the increased incidence of cobalamin deficiency in the elderly. Other causes of food-cobalamin malabsorption include long-term use of proton pump inhibitors (PPIs) and H_2-receptor antagonists, and subtotal gastrectomy.

Other gastrointestinal causes

• **Total gastrectomy** – patients do not produce IF and develop cobalamin deficiency once the body stores are depleted (which can take three to five years).

• **Zollinger-Ellison syndrome** – hypersecretion of gastric acid inactivates pancreatic proteases in the duodenum thereby preventing liberation of cobalamin from gastric R binder and the subsequent binding of cobalamin to IF.

• **Blind loop syndrome** – a condition of stasis of the small intestine, which allows bacterial colonisation and results in bacteria competing for dietary cobalamin with the host.

• **Terminal ileum disorders** – the terminal ileum is where uptake of the cobalamin-IF complex occurs. Thus, conditions like ileal resection, regional ileitis, coeliac disease and Crohn's disease can lead to deficiency.

• **Fish tapeworm** (Diphyllobothrium latum) – the tapeworm resides in the small intestine and competes with the host for ingested cobalamin.

• **Congenital disorders** – eg transcobalamin II deficiency.

• **Drugs** – metformin, calcium-channel blockers and colchicine are implicated in vitamin B_{12} deficiency because they impede absorption at the terminal ileum. Nitrous oxide and large doses of ascorbic acid can destroy cobalamin.

Diagnosis

• **Plasma cobalamin measurement.** In general, diagnosis of vitamin B_{12} deficiency is typically based on serum measurements of cobalamin levels along with clinical evidence of disease. However, in the light of new findings and observations, the specificity and sensitivity of serum cobalamin testing is now being questioned.

Recent findings have shown that many patients with low serum cobalamin levels are not deficient (false-positive values) whereas significant clinical manifestations may occur in some patients despite normal values (false-negative). Some studies have shown that older patients can present with clinical manifestations of neuropsychiatric disease in the absence of haematologic findings.

False-positive results can occur in a number of situations including folate deficiency, pregnancy, excessive vitamin C intake and multiple myeloma. False-

negative results may occur in true deficiency, active liver disease, autoimmune disease, lymphoma and myeloproliferative disorders.

• **Plasma methylmalonic acid (MMA) and homocysteine (Hcys) measurement.** The major diagnostic challenge is identifying cobalamin deficiency at the preclinical stage, so that immediate treatment can avert complications. Thus, substantial research has focused on identifying early biochemical markers of cobalamin deficiency.

Two cobalamin dependent enzymatic reactions occur in humans. In the first reaction, methylmalonic acid (MMA) is converted to succinyl-coA with cobalamin acting as a cofactor. In the second reaction, homocysteine (Hcys) is converted to methionine with cobalamin and folic acid acting as cofactors.

Serum MMA and Hcys test results have been shown to be elevated in 90 per cent of patients with cobalamin deficiencies. Measurements of serum MMA and Hcys have been shown more sensitive in diagnosing deficiency than measurement of serum cobalamin levels alone. However, assays for MMA and Hcys have several pitfalls. An elevated MMA level is more specific than elevated Hcys because folic acid deficiency can also cause elevation of Hcys levels. Thus, folic acid status must be checked in patients found to have hyperhomocysteinaemia.

Additionally, MMA levels can be elevated in patients with renal disease (reduced urinary excretion) thereby giving false-positive results. Other limitations of MMA tests include its high cost and poor accessibility. Disadvantages associated with Hcys measurements include low specificity (it is influenced by smoking, alcohol and coffee consumption), and a tendency towards false-positive results in vitamin B_6 deficiency and reduced renal function.

In cases where serum cobalamin is borderline, a serum Hcys or serum MMA test can be carried out for more diagnostic specificity.

• **Plasma holotranscobalamin measurement.** The amount of cobalamin available for the cells in the form of holotranscobalamin (cobalamin attached to transcobalamin II) should theoretically be a sensitive marker of the metabolically active fraction of circulating cobalamin. Recently, tests for measuring holotranscobalamin have been introduced and some studies have shown them to be an early marker of vitamin B_{12} deficiency.

Although holotranscobalamin measurement is expected to have high sensitivity, its specificity is under scrutiny. For example, it has been found that elevation of transcobalamin associated with inflammation may limit the diagnostic value of this test.

Treatment

Once deficiency has been confirmed, the standard treatment consists of intramuscular administration of pharmacological doses of cobalamin.

• Irreversible aetiologies of cobalamin deficiency, eg PA and total gastrectomy, necessitate lifelong treatment. There is little place for the use of low dose oral cobalamin. In the UK, in the absence of neurological involvement, the initial treatment consists of six injections of hydroxocobalamin 1mg at intervals of two to four days, followed by 1mg every two to three months for life. Where there is neurological involvement, initial treatment consists of 1mg hydroxocobalamin administered on alternate days until there is no further improvement, followed by 1mg every two months for life.

• Reversible aetiologies, eg nutritional deficiency in strict vegans, warrant acute parenteral treatment, then oral cobalamin supplements or twice-yearly injections.

Oral vs parenteral therapy

As mentioned above, 1 per cent of cobalamin is absorbed by IF-independent passive diffusion in the small intestine. Daily high doses of oral cobalamin have shown to be as efficacious as injections in the treatment of PA and other cobalamin deficiency states. Further, a recent Cochrane review of two trials confirmed that daily oral therapy may be as effective as intramuscular therapy in attaining short-term haematological and neurological responses in vitamin B_{12} deficient patients. High oral doses of cobalamin are used (one to 2mg daily) but the practice is rare outside Sweden and Canada and the drug is unlicensed in the UK.

Dinesh Jivanji, MRPharmS, PgDip (Pharm), is a community pharmacist and freelance medical writer.

References available at: www.chemistanddruggist.co.uk/update

Continuing Professional Development CPD

Act

- Revise the structure, formation and destruction of red blood cells.
- Make brief notes on the different types of anaemia and their causes.
- Read the British National Formulary section on drugs used in anaemias, particularly megaloblastic anaemias, as well as the Clinical Knowledge Summary at www.tinyurl.com/23a3vk
- From which foods might strict vegans obtain vitamin B_{12} and how much of each food would provide the recommended daily amount? Do you have vegan customers who might need supplements? (The site www.pagb.co.uk gives access to the Health Supplements Information Service).
- Check your PMRs to trace patients taking PPIs and H_2-receptor antagonists on a long-term basis. Metformin, calcium-channel blockers and colchicine are also implicated in cobalamin deficiency. Might these patients be at risk? Make a note for when you do their next MUR.
- Do you have patients with atrophic gastritis, subtotal gastrectomy or any of the conditions listed in the article under 'Other gastrointestinal causes'? Are they likely to be at risk of cobalamin deficiency? What should you do about it?
- Find out more about the effects of high doses of vitamin C on cobalamin. What are the risks of taking high doses of folic acid in undiagnosed megaloblastic anaemia?
- Do any of your patients have prescribed hydroxocobalamin injections? Does their treatment comply with that described in the article?

Evaluate

Are you now more knowledgeable about the causes of cobalamin deficiency? Would you be confident enough to refer suspect cases? Could you answer questions patients might have about their treatment?

Pharmacists want prescribing support

Asha Fowells

The vast majority of pharmacists are aware of supplementary prescribing, but most feel they do not have enough support to undertake the training.

Over 1,700 pharmacists in Great Britain were surveyed for the research, which appears in this month's International Journal of Pharmacy Practice. Although nearly all were aware of pharmacist supplementary prescribing, fewer that three quarters were aware of courses on offer.

Furthermore, over a third said they were more likely to undertake training once the programme covered both supplementary and independent prescribing.

There was a great deal of uncertainty about the legal requirements of clinical management plans, conditions that could be managed and drugs available for use.

The study authors say their findings indicate pharmacists' enthusiasm for a prescribing role, but highlight concerns over hurdles to its widespread introduction. IJPP 2007; 15(4): 319-325.

Varenicline concerns

Health professionals and patients should be aware of possible effects of varenicline on driving, and patients should be warned not to drive until they know how varenicline affects them.

The warning from the MHRA follows an FDA announcement that it was evaluating reports of drowsiness in patients taking the stop-smoking drug, and of suicidal ideation and one case of erratic behaviour leading to the death of the patient.

The SPC for varenicline advises particular care should be taken in patients with a history of psychiatric illness.

Target ED men for heart risk call

A study published by the International Journal of Clinical Practice has added to evidence that erectile dysfunction predicts cardiovascular disease, and that men with ED should be targeted for prevention.

The authors noted recent Princeton II guidelines emphasising this approach.

UK men's health experts quoted by the GP newspaper Pulse have called for cardiovascular disease prevention based on ED to be included in the QOF.
Int J Clin Pract 2007; 61: 2019–25

NPSA fire warning

Leaflets on the fire hazard presented by paraffin-based emollients used with dressings or clothing are now available. The National Patient Safety Agency is advising pharmacists to counsel patients using products such as white soft paraffin and emulsifying ointment on the potential fire risk, particularly if they smoke. Patients should also be advised to regularly change clothing or bedding impregnated with paraffin-based products. See www.npsa.nhs.uk for more information.

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A Practical Approach — Insomnia supplements

Bethany Straker

"Mr Spencer, could you come out here, please?" Hannah, the senior medicines counter assistant at Update Pharmacy, calls to pharmacist David Spencer. "John Valetta's just tipped a carrier bag full of his medicines all over the counter."

"Is he the fellow with bipolar disorder?" asks pre-registration trainee Julia O'Reilly.

"That's him," sighs David. "Hello John, how can we help you today?"

"Feeling really awful at the moment, guv. Really low, you know?"

"So what would you like me to do about it? And what's with all these medicines?"

"Want your help, of course," replies John. "Can't bloody sleep."

"Well, let's start by getting you and your medicines into the consultation area."

There, David discovers that the medicines are a jumble of prescribed and OTC medicines, vitamins and supplements, some new, others old or out of date. The prescribed medicines bear the labels of several pharmacies.

"This is going to take some time," David says. "It might be easier for you to come back another day so I can sort them out properly. But for now, tell me exactly what the problem is and what you're taking."

John fishes out his current medication: lithium carbonate, fluvoxamine and zolpidem tablets. "That's what I'm on, but they're useless. Can't get no sleep. So I went online and ordered these. The website said they would do the trick," he says, picking up packs of l-tryptophan and melatonin capsules. "Been taking 'em for a fortnight, but they're not making any difference. Feeling worse, if anything."

"You must stop taking those right away," says David.

Questions

1. What do l-tryptophan and melatonin do?
2. Why does David say that John must stop taking them immediately?
3. Is there anything David can do to help John?

CPD

This article can help in the following CPD competencies: **G1a, G1c, G1e, C1c, C1f, C3e.** See www.tinyurl.com/194zu

Answers

1. Tryptophan is an essential amino acid that acts as an immediate metabolic precursor of the neurotransmitter serotonin, which regulates mood and emotion. It has been indicated in the treatment of sleep disorders because it acts as a precursor for melatonin, a neurohormone responsible for regulating sleep cycles. Both have the advantage of not limiting cognitive performance or interfering with arousal from sleep, as some hypnotics do.
2. Tryptophan is subsequently converted to serotonin, and its concomitant use with antidepressants is potentially hazardous. Most antidepressants increase the level of neurotransmitters, including serotonin, at the neuronal synapse. So, taking an SSRI, such as fluvoxamine, together with tryptophan may significantly increase the level of serotonin in the synapse. This could precipitate an interaction known as serotonin syndrome, characterised by agitation, confusion, delirium, tachycardia, diaphoresis, fluctuations in blood pressure, and extrapyramidal side effects.
3. Melatonin is metabolised in the liver by the enzyme CYP1A2. Fluvoxamine is a potent inhibitor of CYP1A2 and therefore will cause an increase in blood levels of melatonin, with increased daytime drowsiness. Interactions have also been reported between melatonin and zolpidem.
4. Little, beyond sorting out his medications and making sure he knows what he should be taking and why. The rest is a problem that John's psychiatrist would have to try to resolve.

Clinical Alerts

Supply issues

Colofac 135mg tablets (mebeverine). Manufacturer reporting supply problems. Solvay Healthcare, tel: 02380 467000.

New products

Curatoderm 4mcg lotion 30ml (tacalcitol). Reckitt Benckiser, tel: 01482 326151

Atripla tablets (efavirenz 600mg, tenofovir 300mg, emtricabine 200mg). Gilead Sciences, tel: 01223 897400

Optaflu [illegible] syringe (influenza vaccine). [illegible] chicken/egg protein [illegible]

[illegible] 3mg/ml syrup ([illegible]). [illegible], tel: 01582 [illegible]

Cetraben cream 150g. New pack size replaces 125g tube. Genus, tel: 01635 568400.

SPC changes

Protium range (pantoprazole). Inclusion of recommended dosage for adolescents.

Detrusitol range, including XL (tolterodine tartrate). New side effects added.

Cardura tablets (doxazosin). Retrograde ejaculation added to undesirable effects.

Avandia 4mg and 8mg tablets (rosiglitazone). Removal of contraindication of use with insulin. Warning on need for increased monitoring if used with metformin and insulin.

NovoMix 30 Penfill and FlexPen (human insulin, insulin aspart). Warning on use with pioglitazone.

Casodex 150mg tablets (bicalutamide). Anaemia and thrombocytopenia added to side effects.

Mitomycin-C solution for injection (mitomycin). Undesirable effects section rewritten.

Xalacom eyedrops (latanoprost, timolol maleate). Removal of Peyronie's disease and lupus as timolol side effects.

Kaletra capsules and oral solution (lopinavir, ritonavir). Updated information on co-administration with rifampicin.

www.emc.medicines.org.uk

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Meldex acquires Kudos range

The Kudos vitamins and herbals range is now owned by Meldex International.

There are more than 100 products in the Kudos range, some of which have been enhanced by the use of the new parent company's patented polymer technologies. Kudos 24 anti-ageing sachets have been reformulated with added calcium, says Meldex.

Press advertising will begin in the spring with ads running in women's glossies including Good Housekeeping and Red magazine, and in Sunday newspaper magazine supplements.

Product info:
Meldex International
Tel: 01256 773299

Octenisan extends

Octenisan antimicrobial hair and body wash is newly available to the community pharmacy sector in a 150ml format. It joins the existing 450ml variant on shelf.

The introduction follows success in the hospital sector, says manufacturer Schülke Mayr. It contains the antimicrobial ingredient octenidine.

Price: £3.99
Pip code: 333-6765
Schülke Mayr
Tel: 0114 254 3500

Products in brief

Call Ceuta for Y&P

Teen skincare brand Young & Pure has appointed Ceuta Healthcare as distributor. Ceuta Healthcare Tel: 01202 780558.

Parental guidance

Understanding Children's Illnesses is the latest title in the Family Doctor series. By Dr Teresa Kilgour, the book aims to help parents better understand the more common childhood illnesses. Conditions such as asthma and head lice are covered, with many colour illustrations. Price: £4.75, Pip code: 333-7045 Family Doctor Publications Tel: 01202 668330.

Snappy expansion

Jeff Scowen Photographic Wholesalers has increased the number of lines it carries. Alongside, IT and communications systems have been upgraded.

Among the newcomers is the Accessory Power range of accessories covering all a photographer needs from cleaners through to USB connections.

Product info:
Jeff Scowen Photographic Wholesalers
Tel: 01275 872255


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or email accumulator@actavis.co.uk

Triple whammy for Anadin

A consumer advertising campaign for Anadin Extra is underway. The activity aims to convey the 'triple action is best' for tension headaches message.

Recent research involved nearly 2,000 people aged 18 to 65 years in Germany. The multi-centre, randomised, double blind placebo-controlled study used a combination of aspirin, paracetamol and caffeine, the ingredients found in Anadin Extra.

Ads are running on national television channels and in the women's press aiming for a female audience aged 35 and over.

Product info:
Wyeth
Tel: 01628 604377

You need hands

Periproducts, the oral hygiene company, has branched out with the launch of a handcare range. Both products in the Hands First range are hypoallergenic and dermatologically tested.

Hands First Invisible Gloves Dry Feel Barrier Cream is designed to be applied before manual tasks or adverse conditions, while Dual action Hands First Power Scrub+ & Moisturiser cleanses and exfoliates.

Initially available on the brand's website, Hands First will be available to independent pharmacies from January.

Prices: Dry Feel Barrier Cream £7.99/125ml; Power+ & Moisturiser £5.99/225ml
Periproducts
Tel: 020 8868 1500
www.handsfirst.co.uk

Products advertised on TV next week

Ambi Pur: All areas
Benylin Cold&Flu Max Strength Capsules: All areas
Benylin Chesty Coughs (Non-Drowsy): All areas
Bonjela: C4, five, Sat
Covonia: GMTV, Sat, five
Gaviscon Liquid and Handy Pack: All areas
Gaviscon Double Action: All areas
Night Nurse: All areas
Nurofen Express: All areas
Optrex: All areas
Rennie Dual Action: All areas
Senokot Dual Relief: All areas
Seven Seas JointCare & CLO: All areas
WindSetlers and Setlers Heartburn: GMTV, five
PharmaSite for next week: Nurses – windows, **Nurses** – in-store, **Nurses** – dispensary
Pharmacy channel: Murine, Senokot Dual Relief, British Heart Foundation

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Aloclair nozzles up

A new gel format has been added to the Aloclair mouth ulcer treatment range. The gel is supplied in a tube with a long nozzle, enabling application to the affected area without using the fingers or a separate applicator.

Aloclair gel contains no alcohol and is suitable for children and adults. It is said to form an invisible film over the ulcer for prolonged protection.

PR and consumer advertising support the launch. Point of sale materials are available.

Price: £3.19/8ml
Pip code: 330-7055
Dexcel Pharma Ltd
Tel: 01327 312266

Future is orange with Organix

Orange Soft Rusks have been added to the Organix children's food range.

Made with wholegrain flour and orange oil, the rusks are sweetened with grape juice rather than sugar.

The rusks have a rounded shape designed for little fingers to hold, says the company. They are suitable from the age of seven months and are packaged in twos for freshness. As well as offering them as they are, the company suggests crumbling the rusks into milk or cooled boiled water and mixing to a smooth consistency.

Price: £1.69/12
Organix
Tel: 01202 479701

Unilever roll-ons are turned upside down

New product development across the deodorant category has been unveiled by Unilever.

Across its brands, a new upside down roll-on design is being introduced. It is designed for consistent dosing and smooth application, says the company.

Further developments include the launch of Sure Girl, a new range for teenagers, and Impulse True Love, designed to appeal to a late teen audience.

Sure for Women has been extended with the addition of Sure Skin Care, three products said to proactively care for underarms.

Dove Go Fresh is a new trio of products, positioned as offering additional freshness benefits alongside the brand's traditional skincare proposition.

The products, packaged in bright green and yellow, are expected to attract younger users to the brand.

Lynx 3 claims to be a new concept in male grooming. The product comprises two cans of different fragrances that can be used separately or in combination to create a third fragrance.

Lynx Dry is being relaunched to include a new fragrance and new pack designs for improved shelf stand out.

Meanwhile, Dark Temptation is a new Lynx fragrance, said to offer the 'irresistible effect of chocolate'.

Sure for Men is being relaunched with new packaging and formulations and Sure Quantum is a new variant.

Support for the brands includes £19 million to be spent across Lynx doeodorant and shower products and £5.4m on Sure for Men.

Product info:
Unilever
Tel: 0208 4396100

Keep in the pink

The Pinks Organic range of manicure and pedicure products has been launched by Pinks Boutique.

Products for feet are inspired by the Himalayas, says the company, and include Crystal foot soak, Foot balm and Massage Oil. Manicure variants include a Hand soak and Cuticle oil, scented with ylang ylang, neroli and sweet orange.

Prices: from £10 to £16.50
Pinks Boutique
Tel: 01332 204804

Tisserand growth

Tisserand has launched two organic cream body washes. Both free from parabens, the products contain essential oils, moisturisers and cleansers.

The lavender variant is said to be relaxing, rebalancing and moisturising. It contains aloe, sea fennel, mallow and calendula.

For a reviving shower, the tea tree and lime cream body wash has 20 essential oils and herb extracts.

Price: £7.70
Tisserand
Tel: 01273 325666

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NEW!

New product that can help to reduce fat absorption

More than half of all adults in the UK are overweight or obese but a new product is now available as an alternative to prescription fat-binding drugs, without the unpleasant side effects.

A new survey has found that two thirds of people worry about the amount of fat they consume each day[1], which is not surprising when you consider that the average British diet contains 34 per cent fat against the recommended daily intake of 20 per cent – that's just 50g for men and 40g for women.

LIPObind helps to naturally reduce the amount of fat the body absorbs from food. It's a certified medical device made from dried cactus extract, which in clinical tests has been shown to help reduce the amount of fat absorbed by the body.[2] LIPObind creates a bulky fat-fibre complex, which can make you feel more full and less likely to continue eating.

LIPObind is taken after food and immediately attaches to dietary fat in the stomach, creating a fat-fibre complex that is too large to be absorbed by the small intestine and then naturally passes through the body.

LIPObind has a rrp of £24.95 for 60 tablets. Call Ceuta Healthcare on 01202 780558 or visit www.lipobind.com for more information.

1. Survey by 72 Point of 4,000 adults conducted in July 2007.
2. Pilot Clinical Study on Fat Binding – data on file.

LIPObind is being supported by a year round national advertising and PR campaign

Effective weight management is a long-term commitment and may involve some small lifestyle changes. A healthy diet with a regular exercise regime and reduction in toxins such as smoking, caffeine, salt and sugar all contribute to a healthy body and mind.
LIPObind® is a licensed medical device product (MDD 93/42/EEC) with approved indications for weight management, appetite and cravings reduction and lowering of blood cholesterol.

The support act

Support staff can run successful weight loss and smoking cessation services, Jennifer Richardson finds, boosting their job satisfaction and freeing up pharmacists' time

Christmas is coming, the goose is getting fat. And so are we. A government report has estimated that nearly a quarter of adults in England are currently obese, and that this proportion could rise to almost 60 per cent by 2050, costing society £50 billion a year at today's prices.

Another huge public health problem is smoking, which costs the UK economy up to £1.7 billion a year by the Department of Health's calculations. According to Nice, around 120,000 people in the UK are killed by smoking-related diseases each year, making it the biggest single preventable cause of death in this country.

But if these figures are scary, there's also evidence we are waking up to the issues. The latest NHS data suggests that 75 per cent of adults in England support the smoking ban, with cigarette sales down 7 per cent in the month following its introduction on July 1, according to market research group AC Nielsen. And a survey by diet aid LIPObind indicated that two-thirds of respondents worry about the amount of fat they consume.

Less reassuring, though, is LIPObind's finding that 45 per cent of those interviewed had "no idea" what their recommended daily fat intake was. And that's where you, the pharmacist, comes in.

Or is it? Pharmacists and even local health authorities are realising that smoking cessation and weight loss services can be run largely by pharmacy support staff, including dispensing technicians and medicines counter assistants, with the pharmacist stepping in only when clinical advice is required.

An excellent example of this comes from NHS Fife, which is currently piloting a support staff-led weight management service funded by the health board. In 10 pharmacies across the region, support staff see up to 20 patients once a week for the first five weeks and on alternate weeks thereafter, measuring weight, body mass index and blood glucose, and offering healthy eating and lifestyle advice.

NHS Fife pharmacy support staff officer Carole Muir says the service was a response to the demands placed on Scottish pharmacists by the new contract to take on more clinical roles. "We had to very quickly build the capacity of pharmacy technicians in order to free up pharmacists' time to become involved in the new schemes," she explains.

Andrew MacDonald, whose Rosewell Pharmacy in Lochore is one of the 10 taking part in the NHS Fife scheme, agrees that he couldn't run a successful weight loss clinic by himself. And Cath Boury says the same of the smoking cessation service at Newland Community Pharmacy in Hull. "It works because I can't dedicate half an hour to go through the programme with [a patient], whereas I can allow a member of staff that full half hour," Ms Boury says.

It's not just the pharmacist who wins. Obviously patients stand to gain from a well-run service, and Newland Community Pharmacy has an 84 per cent quit rate. But Mr McDonald thinks that patients enjoy a support staff-led weight loss or smoking cessation service more than they would a pharmacist-led one, he says, because of the relative informality. "It's a relaxed atmosphere for the patients." ▶

"The support staff know the demarcations of their role"

Carole Muir

"I can allow a member of staff that full half hour"

Cath Boury

And the support staff themselves benefit from running these services. "It gives them more job satisfaction because they follow the patient through," Ms Boury says. If you need it straight from the horse's mouth, one of the technicians running Newland Community Pharmacy's stop smoking programme, Jeanette Walker, says: "It's a very satisfying achievement, helping someone else quit smoking."

Sounds great, but how do you go about creating a support staff-led smoking cessation or weight management service? "Pharmacists looking to involve their staff should certainly invest in suitable training," says UniChem professional services manager Meera Sharma. The role of support staff was "crucial" in UniChem's award-winning obesity management programme in Coventry, Ms Sharma says. NHS Fife provides a central training programme for its service, and Ms Boury's staff are trained smoking cessation counsellors.

Staff must also be made fully aware of standard operating procedures and other guidelines, such as when to refer to the pharmacist and what to do in an emergency, Ms Sharma says.

Ms Muir agrees this is central to the NHS Fife scheme. "The support staff know the demarcations of their role and the SOPs and protocols are very clear about when it's time to refer to a pharmacist. These things have to be in place," she says.

After that, loosening the reins comes down to knowing your limits and appreciating your staff's strengths, says Ms Boury. "Your staff know more about the products than you do. They have excellent communication skills, and customers respond very well to staff input."

But if you don't want or need staff to run the service themselves, they can be involved at various levels of service provision. The Co-operative Pharmacy's smoking cessation services range from technician-led to pharmacist-only, says director of pharmacy practice Liz Colling. But even in schemes where the pharmacist carries out the actual consultation, staff can support service delivery by identifying suitable patients, booking appointments and organising the paperwork, Ms Colling says. "It relieves pressure on the pharmacist to concentrate on the things that only a pharmacist can do."

But Ms Colling has one final word of warning for those looking to involve their staff in smoking cessation and weight management services: "Once the staff get hooked on it, they push the pharmacist to do more and more."

UK health problems

60%

The proportion of the UK population predicted to be obese by 2050

120,000

The number of people in the UK killed by smoking-related illnesses each year

Product news

On fire, but not smoking

[illegible] national TV campaign, and the distribution of placebo samples and leaflets at games.

Pharmacy materials and training support is currently being developed to support this surge of activity.

www.keepthefire.co.uk

Fat fears

A survey of 4,000 adults by certified medical [illegible] aid LIPObind has discovered that two-[illegible] of people worry about the amount of fat they consume.

Made from dried cactus extract, LIPObind [illegible] absorption of 27 per cent of fat from a standard meal, manufacturer Goldshield Healthcare claims.

The tablets come in a pack of 60 with an RRP of £24.95.

www.lipobind.com

Patch power

Pharmaceutical company Wockhardt has launched transdermal NRT patches Nicopatch.

The 24-hour patches come in 7mg, 14mg and 21mg strengths, all in packs of seven at an RRP of £15.49.

www.helpingyouquit.co.uk

NiQuitin provides support to help smokers successfully Quit

Many attempts to stop smoking fail because people quit 'cold turkey', the most ineffective method of giving up.[1] Many smokers also have misconceptions about the safety of nicotine replacement therapy (NRT), with over two thirds of smokers incorrectly believing that NRT is just as harmful as cigarettes.[2] Pharmacists have an important role to play in dispelling these misconceptions. Although addiction to nicotine is a fundamental reason people keep smoking, it is the exposure to some of the 4 000 other chemicals from cigarette smoke that can kill.[3] Therapeutic nicotine combined with behavioural support from a healthcare professional can increase a smoker's chances of quitting by up to six times compared to willp ower alone.[1]

Did you know?

Without therapeutic nicotine, 50-75% of quitters will relapse in 1 week.[4-5]

Therapeutic nicotine can help smokers Quit for Good

Smoking increases the number of nicotine receptors in the brain .[6-8] When a smoker quits, these receptors no longer get the nicotine they need causing withdrawal symptoms and cravings. NiQuitin releases therapeutic nicotine which targets the nicotine receptors to relieve cravings.

NiQuitin's Step Down Programme weans the receptors off nicotine gradually reducing a quitter's nicotine intake to zero. This helps to give smoker's willpower a fighting chance to break the habit of smoking.[7] Using NiQuitin doubles a smoker's chances of quitting successfully compared to willpower alone.[9]

NiQuitin

The NiQuitin range offers quitters a choice in the format of therapeutic nicotine they feel suits them best to help them quit for good.

NiQuitin Lozenge and Mint Lozenge

The NiQuitin 4mg Lozenge provides flexible therapeutic nicotine delivery to help 5 out of 10 smokers remain quit at 4 weeks[10]

NiQuitin Lozenges are suitable for quitters who are most worried about situational triggers and want to be able to respond quickly as and when cravings occur. Situational cravings are a main cause of lapse, and left untreated they can sabotage willpower and may cause lapse to smoking within 11 minutes.[11] NiQuitin 4mg Lozenge offers craving relief within 5 minutes and so rapidly relieves situational cravings.[12]

NiQuitin 4mg Lozenge has the additional advantage of reducing the weight gain associated with the 12 week quitting process. [10]

NiQuitin Patch

The NiQuitin 21mg Clear Patch provides continuous therapeutic nicotine delivery to help 6 out of 10 smokers remain quit at 4 weeks[13]

NiQuitin Patch is suitable for smokers who are most worried about being irritable and difficult to be around whilst quitting and want protection from cravings throughout the day.

The NiQuitin Patch provides a continuous delivery of therapeutic nicotine to the body over 24 hours by using a special rate controlling membrane. This is important as many smokers experience strong cravings in the morning after waking.[14]

The patch may be particularly suited to smokers who prefer:

- Convenience – to put on a patch and forget about it
- Discretion – the clear patch is suitable for any skin tone
- Reassurance that they will be protected throughout the day

Nicotine

The Click2Quit support plan

Smokers looking to quit can access NiQuitin's personalised online smoking cessation support plan via www.Click2Quit.com. Developed by experts, the 10 week plan is designed to be used alongside NiQuitin stop smoking aids as a way of supporting smokers to break the habitual side of smoking. The Click2Quit plan is personalised based on answers provided by the individual quitter and includes regular tips, motivational messages and advice sent directly by email. The new Click2Quit 2.0 plan also includes an optional SMS support program to provide support to quitters while on the go.

Training support from GSK

GSK Consumer Healthcare is continuing to support training in pharmacy with the launch of a series of high quality distance learning modules for pharmacy. The first module focuses on smoking cessation and aims to help pharmacists and assistants improve their support for quitters. The initiative is part of the new 'Ask Your Pharmacist First' campaign. To obtain the modules visit *www.MyPharmAssist.co.uk* or ring 0800 783 3927.

NiQuitin 2mg/4mg Lozenge and Mint Lozenge (nicotine). For relief of nicotine withdrawal symptoms, abrupt/gradual smoking cessation. **Dosage: Adults (18 and over):** *Abrupt cessation:* 4 mg if smoke within 30 minutes of waking. 2 mg if longer. Weeks 1 to 6, 1 lozenge every 1 to 2 hours (min. 9, max. 15/day). Weeks 7 to 9, 1 lozenge every 2 to 4 hours. Weeks 10 to 12, 1 lozenge every 4 to 8 hours. Weeks 13-24, 1 to 2 lozenges per day only when strongly tempted to smoke. Professional advice if use beyond 9 months. *Gradual cessation:* Prior to schedule above use a lozenge (max. 15/day) when strong urge to smoke to reduce cigarette consumption. Professional advice if no reduction after 6 weeks/quit attempt after 6 months. *Temporary cessation:* 1 lozenge every 1 to 2 hours (max. 15/day). Professional advice after 6 months if using regularly and no quit attempt made. **Adolescents (12-17 years):** As for adults abrupt cessation, but to seek professional advice if more than 12 weeks treatment required or unable to quit abruptly. **Contraindications/Precautions:** Hypersensitivity, cardiovascular disease, urticaria, severe renal/hepatic impairment, phaeochromocytoma, hyperthyroidism, diabetes, phenylketonuria, low sodium diet. Swallowed nicotine may exacerbate oesophagitis, gastric/peptic ulcer. **Side effects:** Depression, irritability, anxiety, insomnia, headache, dizziness, cough, cold. Nausea, hiccup, flatulence, GI disturbance, appetite change, oral irritation/ulceration, nightmares, restlessness, mood change, pharyngitis, thirst, taste/sensory disturbance, dyspnoea, respiratory disorders, rashes, itching, sweating, numbness, flushes, vascular disorders, halitosis, chest pain, throat swelling, leg oedema, pain, malaise, wakefulness, palpitations, tachycardia, tooth/jaw ache, nocturia. See SPC for full details. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. GSL **PL** 00079/0606, 0607, 0369 & 0370. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** 36's £8.03, 72's £15.63. **Date of revision:** November 2007.
NiQuitin 21, 14, 7mg Transdermal Patches, NiQuitin Clear 21, 14, 7mg (nicotine). Opaque or transparent transdermal patches 21mg, 14mg, 7mg nicotine (Steps 1, 2, 3) for relief of nicotine withdrawal symptoms during smoking cessation. **Dosage: Adults (18 and over):** *≥10 cigarettes/day:* Step 1 for 6 weeks, then Step 2 for 2 weeks, then Step 3 for 2 weeks. *<10 cigarettes/day:* Step 2 for 6 weeks then Step 3 for 2 weeks. Apply to fresh site (clean, dry skin) once daily. Professional advice if use beyond 9 months. **Adolescents (12-17 years):** As for adults but to seek professional advice if more than 12 weeks treatment required. **Contraindications/Precautions:** Hypersensitivity, cardiovascular disease, severe renal/hepatic impairment, hyperthyroidism, diabetes, phaeochromocytoma, dermatitis. **Side effects:** Local rash, itching, burning, tingling, numbness, swelling, pain, urticaria, heaviness. Depression, irritability, anxiety, nervousness, restlessness, mood lability, drowsiness, impaired concentration, insomnia, sleep disturbance. Allergic reactions, abnormal dreams, nausea, vomiting, dry mouth, GI disturbance, headache, dizziness, palpitations, tachycardia, tremor, dyspnoea, pharyngitis, cough, arthralgia, myalgia, sweating, chest pain, fatigue, malaise, flu-like symptoms. See SPC for full details. **Pregnancy/lactation:** For those unable to quit unaided the risk of continued smoking is greater than the risk of using NRT. Start treatment as early as possible in pregnancy for 2-3 months. Lozenge/gum preferable to patches unless nauseous. Remove patches at bedtime. GSL **PL** 00079/0366, 0367, 0368, 0356, 0355 & 0354. **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** All strengths 7 patches £15.63; Step 1 only 14 patches £29.44. **Date of revision:** July 2007. **NiQuitin** and **Click2Quit** are registered trade marks of the GlaxoSmithKline group of companies.

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When the boat comes in

Pre-registration trainee Lindsay Richardson, of Buchanhaven Pharmacy in Peterhead, checks merchant ships' medicine stores to ensure they comply with UK regulations

Peterhead is one of the main ports for a number of oil-related companies and has a sizeable fishing industry; as a result, there are always boats berthed here. We check the medicine chests aboard merchant vessels and ensure they comply with government regulations.

I was sent out to check a boat on the second day of my pre-reg – my tutor decided it would be excellent experience for me! I was eager to do it, although the legislation had only been briefly covered at university. We'd been left with the impression that it was one of those things you never really did in community pharmacy anymore. You go out to the boat, figure out what it needs and bring it in! We provide the service as and when it's required.

My tutor provided all the information I needed, in terms of what to check and how to go about it. She helped me a great deal with putting together some of the paperwork required, such as lists of drugs with expiry dates and CD requisition forms.

I also re-read relevant parts of Medicines, Ethics and Practice! Other than that it was a learning process in itself. Finding out where to order certain things and how best to lay out the information we give back to the vessel captains was determined more by doing than anything else.

We don't have any costs in providing the service, as such. The updated regulations are

C+D AWARDS 08

See next week's issue to find out more…

In association with

NPA National Pharmacy Association

...provided me from the Stationery Office and the only issues encountered are those of getting in the necessary medicines and equipment, but these are reimbursed from the vessel owners.

A major low point, as far as I'm concerned, is being on the boats themselves. Suffering from horrendous travel sickness and trying to concentrate on checking dates of boxes (some of which have been written in Norwegian) is not the most pleasant experience in the world.

As a high point, I would say being told that we provided a good service to the vessels and, as a result of that, receiving more requests for us to check medicine lockers thereafter.

My advice to other pharmacists thinking of carrying out this service would be to take some travel sickness pills! I'd also say familiarise yourself with what the MEP and the regulations say, and find out where you can get supplies such as splints, forceps and so on, which are often the more tricky things to get hold of. We had one supplier that specifically held stock for merchant vessels.

Be prepared to clamber on to a boat or two – not all of them have removeable medicine lockers! Keep standard forms of things such as medicine lists, certificates of compliance with regulations and CD requisition forms as they'll be needed for all the boats you supply.

> "Suffering from horrendous travel sickness and ... checking dates of boxes (some of which have been written in Norwegian) is not the most pleasant experience in the world"

Under the white coat

- One of the best things about my job is that there's always something to learn. Often it's just little things that crop up and make me think, "I didn't know that, I'll have to remember that." One of the worst is dealing with an irate customer. I'm not a very confrontational person and so I find that a bit difficult to deal with.
- If I was in charge of pharmacy for a day I would... probably panic a lot! I've not yet experienced that much responsibility and I can't get my head around the idea at all. I often wonder if that's a bad sign for a pre-reg!
- When I was little, I wanted to be a marine biologist. I used to think dolphins and whales were lovely. Now, if I wasn't a pharmacist, I'd like to think I'd be a writer, or own a bookshop, maybe.

Out of hours

- To relax, I enjoy a glass of wine (responsibly) with friends, and a good episode of Super Nanny.
- My desert island discs would include, I'm ashamed to admit, any one of the Sugababes' albums.
- I derive an odd satisfaction from popping bubbles in plastic bubble wrap.
- My dream dinner party guests would be Sarah Beeny from that Property Ladder show, to chat about my tiny flat and how to make it worth millions, then Whoopi Goldberg and Victoria Wood for entertainment and wit.
- As I have a partner, my dream date would obviously be him. But if Jake Gyllenhaal were to ask, he might get a hypothetical yes.

C+D

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From: **Hawkeye on the web**

Date: **Sat 8.12.07**

Subject: **Lord Darzi's Second Life**

Delegates in Second Life included a woman with a **monster's head** and a flying **winged angel**

As if being tasked by the Prime Minister to shape the future of the NHS wasn't enough to keep him on his toes, health minister Lord Darzi is also leading a double life.

Well, a Second Life, to be more accurate. Because at the same time he was due to appear at the International Clinical Summit on November 21 in person, Lord Darzi was also scheduled to speak to an assembled crowd of 25 interested observers in the online virtual world Second Life (www.tinyurl.com/33pdoh).

Parliamentary commitments, however, meant that delegates at both events (which in Second Life included a woman with a monster's head and a flying winged angel) eventually had to settle for a video message.

Created by Linden Labs, Second Life (www.secondlife.com) bills itself as a 3D virtual world. It's inhabited by the digital incarnations of millions of people, known as avatars, who are free to run, jump, fly or teleport their way around, socialising with other residents of the online community (or 'metaverse') as they go.

Second Lifers can also create and trade virtual goods and services in the marketplace by converting their own money into Linden Dollars. But this is where the lines of virtual and reality get blurred because the Linden Dollar can be exchanged for real money. The exchange rate is around 270 to the US dollar and last year Ailin Graef became the first real-world millionaire through her Second Life persona, land baroness Anshe Chung (www.tinyurl.com/ud6qp).

As well as commerce, Second Life has generated great interest among learning establishments. The Open University has taken residence on two islands to offer a range of distance learning support.

The University of Florida is looking to develop a virtual pharmacy in Second Life that will enable students to train in a hospital and community pharmacy context (www.tinyurl.com/3d7e5b). The project focuses on communication skills, with one class covering clinical consultations and one looking at pharmacy communication for non-native speakers of English. A case of providing very real training in a virtual world.

What do you think?
Email thawkins@cmpmedica.com

... what's new on the C+D website ... ...

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news education

The top stories on the C+D news bulletin

1 [illegible] back to mid-2008
2 [illegible] may be linked to OTC sales
3 MHRA [illegible] plan
4 RPSGB more [illegible] on trivial complaints
5 [illegible]

Chemist+Bloggist

"Yes, we are human, we do make mistakes and as you've guessed, this is the time to make them and to learn from them"

Numark pre-reg student John-Patrick Foley is making strides in his development as a pharmacist, having already run a diabetes screening service. Read his thoughts about entering the world of pharmacy at [illegible]tinddruggist.co.uk/bloggists

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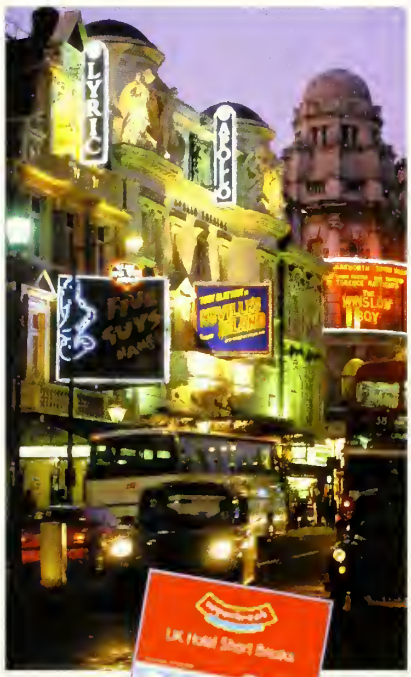
The prize is a London Theatrebreak for two (sharing a twin/double room) or a single traveller to be taken in March or November 2008 or February 2009. It includes overnight accommodation at a 3 or 4 star central London hotel, breakfast, hotel tax/service charges and tickets for a top West End musical (choice of 10 shows). **The prize can be upgraded/extended and/or additional persons added subject to payment of supplementary costs.**



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ABTA The Travel Association

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TRAVELPRIZE

Entry coupon December 07CD

Closing date January 1, 2008

Q Around 120,00 people die in the UK each year due to smoking related diseases

T ☐

F ☐

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Send your entry to: Pharmacy Travel, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE Incomplete entries will not qualify for the prize draw/holiday discount voucher

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Rules 1.This competition is open to any pharmacist or permanent member of staff who works at an address which receives *C+D* 2.Competitors may enter through *C+D*, but may only submit one entry. Double entry will disqualify both entries 3.Entries must be on an original coupon from *C+D* and to be eligible for the prize entrants must correctly answer the question on the coupon 4 The prize offered will be as stated. No alternative holidays or cash prizes will be offered 5 Names of winners will be published in *C+D* 6 In any dispute, the decision of CMP Medica Pharmacy Group's publishing director will be final and no correspondence will be entered into 7.Employees of CMP Medica Ltd, Affinity Travel Services and trading divisions and their immediate families are forbidden to enter 8 No purchase is necessary to participate 9 The closing date for this month's competition is as printed on the entry coupon.

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